IMPLEMENTATION OVERSIGHT WORKGROUP OF THE HEALTH SYSTEM REFORM TASK FORCE

INVITED PARTICIPANTS, OBJECTIVES, AND DUTIES FOR 2010 INTERIM STUDY

INVITED PARTICIPANTS

Legislators:

- Sen.Knudson(co-chair)
- Rep. Dunnigan (co-chair)
- Rep. Newbold
- Rep. Biskupski
- Rep. Litvack

Insurance Department—Tanji Northrup

Utah Health Exchange Risk Adjuster Board—Dave Jackson

Employers—Wes Smith, Salt Lake Chamber of Commerce

Providers

- Scott Barlow, Utah Clinic
- Dr. Robin Price, optometrist
- Utah Medical Association—Michelle McOmber
- Utah Hospital Association—David Gessel

Insurers

- Regence—Scott Ideson, Chet Loftis
- Altius—Todd Trettin, Frank Kyle
- SelectHealth—Greg Poulsen, Mark Brown
- Humana
- United
- Jeff Hartley, America's Health Insurance Plans

Brokers—Ernie Sweat, Utah Association of Health Underwriters

Consumers

- Voices for Utah Children—Kory Capozza
- UHPP—Judi Hilman
- AARP—Laura Polacheck

OBJECTIVES

- Ensure that changes to the Utah Health Exchange and the overall insurance market enacted during the Legislature's 2010 General Session are implemented on time and in accordance with legislative intent. Many of those changes are listed on the following pages.
- Ensure that other changes needed to address concerns raised during the 2010 limited launch of the Utah Health Exchange are identified and addressed to ensure successful full-scale enrollment of the small group market and limited enrollment of the large group market in 2011.
- Ensure proper implementation of pre-2010 reform initiatives, including the development of Medicaid waivers, evidence-based quality measures, and health insurance plans that promote quality improvement and incorporate wellness incentives.

DUTIES

- Review implementation of Utah health reform legislation
- Review other initiatives to address issues raised by the limited launch of the Utah Health Exchange
- Report and make recommendations to the Health System Reform Task Force at its September and October meetings

2010 ENACTED PROVISIONS
LIMITED TO THE UTAH HEALTH EXCHANGE

EXPAND EXCHANGE PARTICIPATION

1. **LARGE GROUP PILOT**

   Allow large groups to participate in the defined contribution arrangement market (DCAM) one year earlier on a pilot basis, beginning January 1, 2011

2. **DEFINED BENEFIT PLANS**

   Allow small groups to purchase defined *benefit* products offered within the DCAM, beginning January 1, 2011

3. **ALL NEW SMALL GROUP PLANS**

   Beginning January 1, 2013, require insurers to post in the Exchange (but not necessarily the DCAM) any small group products accepting new employee groups

EXPAND DCAM OFFERINGS

4. **NEW HDHPs**

   In addition to the Basic Benefit plan already offered in the DCAM, require insurers to offer high deductible health plans with moderate and high deductibles.

5. **MOST POPULAR PLANS**

   Require insurers participating in the DCAM to offer in the DCAM their five most commonly selected plans open to new enrollment and meeting certain conditions

6. **MORE LESS-RICH PLANS**

   Allow insurers to offer additional plans that must be actuarially equivalent to or greater than the new medium-level deductible HDHP plan rather than low-level deductible HDHP (the basic benefit plan)

MODIFY UNDERWRITING/RATING PRACTICES

7. **PORTABLE RISK FACTOR**

   If an employer's insurer outside the DCAM is also participating in the DCAM, allow the employer to enter the DCAM for either a defined contribution plan or a defined benefit plan with the same risk factor (or lower) that the employer would have if renewing with the insurer outside the DCAM (the employer is not required to select the same insurer or plan used outside the DCAM)

8. **INDEPENDENT ACTUARY**

   Require the Utah Defined Contribution Risk Adjuster Board within the Insurance Department to appoint an independent actuary to review the rates, rating factors, and premiums of small and large group plans offered in the Exchange prior to the publication of the rates in the Exchange

9. **UNIFORM UNDERWRITING/RATING**

   Prohibit a small group insurer in the DCAM from using rating and underwriting practices that differ between plans marketed inside the DCAM and plans marketed outside the DCAM, and require that to be verified by the independent actuary

10. **ALL PAYER DATABASE**

    Allow limited use of the All Payer Database for risk adjustment within the DCAM

EXTEND RISK ADJUSTMENT

11. **LARGE GROUPS INSIDE EXCHANGE**

Risk adjust large group plans in the DCAM when they begin to be offered January 1, 2011

12. **SMALL GROUPS OUTSIDE EXCHANGE**

Extend risk adjustment beyond small and large groups marketed in the DCAM to also include small group plans marketed outside the DCAM (including small group plans marketed outside the Exchange), beginning January 1, 2013

MODIFY ADMINISTRATION

13. **ONGOING ENROLLMENT**

Replace annual enrollment with ongoing monthly enrollment for employers in the DCAM

14. **CARRIER ELECTION**

Prohibit a carrier that chooses to not participate in the DCAM by January 2011 from participating until January 2013

15. **APPOINTED AGENTS FOR DCAM**

Allow a person to be appointed by the Insurance Department and listed on the Exchange as a producer for the DCAM if the person:

- makes application to the Insurance Department
- is an appointed agent with the majority of the carriers that offer a defined contribution arrangement plan in the Exchange
- has completed a defined contribution arrangement training session approved by the insurance commissioner

16. **ELECTRONIC UNIFORM APPLICATIONS**

Require an insurer offering a plan in the Exchange to:

- accept and process from the Exchange electronic uniform applications and uniform waivers using the electronic standards established by the Office of Consumer Health Services
- if requested, provide an applicant with a copy of the completed application, either electronically or by mail

17. **ADVISORY BOARD**

Require the Exchange to create an advisory board consisting of two producers, two consumers, two insurers, the Insurance Department, and the Department of Health

18. **INSURER INFORMATION**

Clarify the information an insurer must submit to the Exchange and the Insurance Department

• 2010 ENACTED PROVISIONS NOT LIMITED TO THE UTAH HEALTH EXCHANGE

MODIFY RATING PROVISIONS

19. **CLASS OF BUSINESS (SMALL GROUP AND INDIVIDUAL)**

- Presumption against classes
- Five maximum per carrier
- Must be approved by commissioner, based on same criteria
- None allowed based on whether plan marketed in the Exchange

20. **CASE CHARACTERISTICS**

- Small group

  Limited to:

  - Family composition

– Overall ratio of 5:1 or less – Four tiers:
Employee
Employee + spouse
Employee + dependent(s)
Employee + spouse + dependent(s)

- Age
  - Age bands (for each family tier)
    <20
    5-year bands through age 64
    65
  - For each band, a standard slope ratio range:
    not to exceed 5:1
    not overlapping any other band
    determined by commissioner
- Geographic area

- Individual

Limited to:

- Family composition
- Age
- Geographic area
- Gender
- Others approved by commissioner

21. **ANNUAL INCREASE**

Limit on adjustment for industry class as a case characteristic (15% difference) no longer applies (small group and individual)

INCREASE PRICE TRANSPARENCY

22. **ALL PAYER DATABASE REPORTS**

Direct the Health Data Committee to use the All Payer Database to report on:

- geographic variations in medical care and costs
- certain price increases by providers

23. **HEALTH FACILITY CHARGES**

Require a health care facility to make available to a consumer, upon request, charges for the following:

- in-patient procedures
- out-patient procedures
- the 50 drugs most commonly prescribed in the facility
- imaging services
- implants

24. **PROVIDER CHARGES**

Require a physician, independent practice nurse, dentist, or chiropractor, to make available to a consumer, upon request, charges for the practitioner's 25 most frequently performed:

- clinic procedures or clinic services
- out-patient procedures
- in-patient procedures

INCREASE PRICE TRANSPARENCY

25. **DISCOUNTS**

Require health care facilities and the practitioners listed above to also make available to consumers, upon request, information about discounts for:

- services not covered by insurance
- prompt payment

INCREASE INSURER/PLAN TRANSPARENCY

26. **COMPARISON MEASURES**

Require the insurance commissioner to convene a group to develop data that will allow consumers to compare insurers and plans. The data shall "include consideration of":

- the value and rate of denied claims
- the quality and efficiency of claims administration of other administrative processes
- average out of pocket expenses for plan enrollees
- consumer assessment of each plan or insurer

Require all insurers to report for all plans the data developed above

IMPROVE INSURANCE ADMINISTRATION

27. **SIMPLIFIED APPLICATIONS**

Direct the Insurance Department to develop, with the input of insurers, consumers, and others, shortened and simplified uniform application forms for individual, small group, and large group insurance that:

- is limited, except for cancer and transplants, to 10 years of history
- includes a uniform waiver of coverage which does not include health status related questions other than pregnancy The forms are to be used by Exchange plans beginning October 1, 2010 and other plans beginning January 1, 2011

28. **COORDINATION OF BENEFITS**

- Provide uniform language for divorce decrees and child support orders related to the coordination of health insurance benefits when a dependent child of the marriage is covered by both parents' health insurance policies
- Establish a coordination of benefits process for health insurance claims based primarily on national standards
- Provide uniform educational material for the public regarding the coordination of health insurance benefits
- Repeal the coordination of the health insurance benefits process that was to take effect July 1, 2010

29. **UNIFORM ELECTRONIC STANDARDS**

Amend provisions related to uniform electronic standards for health insurance claims processing, electronic insurance eligibility information, and electronic information regarding the coordination of benefits and establish a voluntary registry of software vendors who comply with electronic standards

30. **BASIC PLAN FLEXIBILITY**

Change the basic benefit plan deductible from the lowest amount allowed under a federally qualified HDHP (individual: $1,200; family: $2,400) to an amount within $250 of the lowest amount allowed

31. **CONVERSION POLICIES**

Authorize and specify how an insurer may discontinue a conversion policy that goes beyond Utah NetCare Plan requirements

32. **SPECIAL ENROLLMENT PERIODS**

Specify that a person is eligible to enroll in an employer group plan within 60 days of:

- termination of coverage under Medicaid or CHIP, if the termination was due to ineligibility
- qualifying for employer coverage assistance under Medicaid or CHIP

33. **PREAUTHORIZATION**

Require an insurer who requires preauthorization or preapproval to provide an enrollee, upon request, with a statement of preauthorization if the applicable CPT codes have been submitted to the insurer, effective January 1, 2011

34. **EXTENSION OF UTAH MINI-COBRA**

Allow an insured to extend Utah mini-COBRA coverage beyond 12 months to the period of time the insured is eligible to receive assistance under the American Recovery and Reinvestment Act of 2009, as amended.

35. **INSURANCE OFFERED BY STATE CONTRACTORS**

Amend the requirement that contractors with certain state entities offer qualified health insurance to their employees by clarifying:

- that the application of a waiting period for health insurance may not exceed the first of the month following 90 days of the date of hire
- that the qualified health insurance coverage must be offered to employees and dependents who work or reside in the state
- that the qualified health insurance coverage that must be offered is a minimum standard and an employer may offer greater coverage
- how an employer offering a defined contribution arrangement may comply with state contract requirements. Also amend:
- the definition of qualified health insurance coverage to clarify standards
- enforcement provisions to provide protections for good faith compliance

PROMOTE PAYMENT AND DELIVERY REFORM

36. **ALL PAYER DATABASE**

Authorize use of the All Payer Database for payment and delivery reform demonstration projects

37. **FINANCING**

Direct the Insurance Commissioner and the Office of Consumer Health Services to apply for financial assistance to create and implement payment and delivery reform demonstration projects

38. **MEDICAID MEDICAL HOME**

Require the Department of Health to determine the feasibility of implementing within existing budget a three-year patient-centered medical home Medicaid demonstration project

39. **MEDICAID HEALTH OPPORTUNITY ACCOUNTS**

Require the Department of Health to seek federal approval to implement a Medicaid health opportunity accounts demonstration project and implement the project with the approval of the Health and Human Services Appropriations Subcommittee

IMPROVE MEDICAID AND CHIP

40. **MEDICAID AUDITS**

Require that Department of Health internal auditing resources be allocated to Medicaid in the same or greater proportion that state funding for Medicaid bears to state funding for the Department. Audits are to address efficiency, cost recovery, fraud, waste, abuse, and compliance with best practices.

41. **DIRECT CONTRACTING**

Require the Department of Health to study and report on the feasibility of contracting directly with providers for primary care services

42. **PHARMACY PRIOR APPROVAL**

Allows the Drug Utilization Review Board to consider cost, in addition to existing

considerations, when determining whether a drug should be placed on Medicaid's prior approval program

43. **SIMPLIFIED CHIP RENEWAL**

Require CHIP, if grant funding is available, to create a simplified renewal process which allows an eligibility worker, if an applicant consents, to confirm the applicant's adjusted gross income with the State Tax Commission

MODIFY MEDICAL LIABILITY LAWS

44. **NON-ECONOMIC DAMAGES CAP**

Amend the cap on non-economic damages that may be awarded in a malpractice action to $450,000 and eliminate the annual adjustment for inflation

45. **"I'm Sorry" PROTECTION**

Amend the Utah Rules of Evidence to provide that: "Statements, expressions, or conduct that express apology, sympathy, commiseration, condolence, compassion, or general sense of benevolence, or describe the sequence of events relating to the unanticipated outcome of medical care or the significance of events or both are not admissible against a health care provider or an employee of a health care provider to prove liability for an injury."

46. **AFFIDAVIT OF MERIT**

Require an affidavit of merit from a health care professional to proceed with an action if a pre-litigation panel makes a finding of non-meritorious

47. **OSTENSIBLE AGENT PROTECTION**

Limit the liability of a health care provider, in certain circumstances, for the acts or omissions of an ostensible agent

48. **DEMONSTRATION PROJECT**

Require the Department of Health to establish a two-year demonstration project to facilitate:

- open and honest dialogue between a health care provider and a patient or the patient's representative regarding unexpected medical outcomes
- appropriate and timely resolution of medical malpractice claims